Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DR. STEPHEN E. EARLE

Respondent Name
LIBERTY MUTUAL INSURANCE CO

MFDR Tracking Number
M4-13-1129-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JANUARY 8, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Sufficient documentation of the procedure is provided; therefore, reimbursement for this procedure code is appropriate."

Amount in Dispute: $4,225.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 63662 59 is not supported as performed and hence the 59 modifier is not supported…Dr. Earle billed CPT 63044 X 1 unit and 63044 50 X 1 unit. CPT 63044 50 was paid @ the billed charge of $1125.00 and CPT 63044 billed without the 50 modifier was denied…The operative report documents revision lumbar spinal surgery bilaterally at L4-5 and L5-S1 interspaces. CPT 63042 50 and 63044 50 are interspace codes and as stated two interspaces were supported and paid for the one unit with the 50 modifier for each code billed according to the correct Medicare guidelines for billing of bilateral surgical codes."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 3, 2012	CPT Code 63662-59	$1,125.00	$754.02
	CPT Code 63044	$3,100.00	$0.00
TOTAL		$4,225.00	$754.02

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
   - 193- Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
   - B12-Services not documented in patients' medical records.
   - X901-Documentation does not support level of service billed.
   - X133-This charge was not reflected in the report as one of the procedures or services performed.

Issues

1. Does the documentation support billing CPT code 63044?
2. Does the documentation support billing CPT code 63662-59?
3. Is the requestor entitled to reimbursement for CPT code 63662-59?

Findings

1. According to the explanation of the respondent denied reimbursement for CPT code 63044 based upon reason codes "B12," and "X133."

   The respondent states that "CPT 63042 50 and 63044 50 are interspace codes and as stated two interspaces were supported and paid for the one unit with the 50 modifier for each code billed according to the correct Medicare guidelines for billing of bilateral surgical codes."

   On the disputed date, the requestor billed codes 63042, 63042-50, 63044, and 63044-50.

   CPT Code 63044 is defined as "Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)."

   CPT code 63042 is defined as "Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar." Therefore, code 63042 is the primary procedure and code 63044 is used for each additional lumbar interspace.

   A review of the submitted explanation of benefits finds that the respondent paid $1,125.00 for code 63044-50 and $1,2407.02 for code 63042-50. The requestor did not dispute the payment for codes 63042-50 and 63044-50.

   According to Medicare Surgery Manual "Modifier 50 represents that the procedure was performed bilaterally. To report bilateral services, bill the procedure with the 50 modifier and a unit of one in the days/units field or electronic equivalent."

   The operative report indicates " The patient then underwent revision lumbar spine surgery at L4-L5 on the right, L5-S1 on the right…Attention was then taken to the patient's left side, where exactly the same procedure was performed." Review of the operative report finds that the requestor did not support billing for an additional interspace of CPT code 63044 in addition to codes 63042-50 and 63044-50. As a result, no reimbursement is recommended.

2. According to the explanation of the respondent denied reimbursement for CPT code 63662-59 based upon reason codes "150," and "X901."

   CPT Code 63662 is defined as "Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed."

   The requestor appended modifier -59 to CPT code 63662. Modifier -59 is defined as "Distinct Procedural Service". Modifier 59 is further defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

   The operative report supports the billing of CPT code 63662; therefore, reimbursement is recommended.

3. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2012 DWC conversion factor for this service is 68.88.

   The Medicare Conversion Factor is 34.0376

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 78233, which is located in Live Oak; therefore, the Medicare participating amount is based on locality "Rest of Texas".

   The Medicare participating amount for code 63662 is $745.21.

   Using the above formula, the MAR is $1,508.04; however, this code is subject to multiple procedure rule discounting = $754.02. This amount is recommended for additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $754.02.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $754.02 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/03/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.